

MCHB/EMSC Webcast

Major Revisions to the Implementation Manual for the EMSC State Partnership Performance Measures

December 4, 2007

DAN KAVANAUGH: Good afternoon, my name is Dan Kavanaugh, the program manager for the Emergency Medical Services for Children Program. And welcome to our webcast today. The title of our webcast today is Revision to the Implementation Manual for the EMSC Performance Measures. This is Tasmeen Singh who is from children's national medical center.

Before we go into the webcast, though, I want to go over some of the technical issues for you to be aware of for our webcast today. First the slides will appear in the central window and they should advance automatically. The slide changes are synchronized with the speaker's presentation. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window.

We encourage you to send questions at any time during the presentation. Simply type your question in the white message window on the right of the interface, select question for speaker from the dropdown menu and then hit send. Please include your state or organization in your message so that we know where you're participating from. The questions we will collect them during Tasmeen's presentation and have about 10 to 15 minutes at the end where we can answer those questions. Those questions that we're not able to get to we will answer after the broadcast and they will be archived for participants to look at.

On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider which you can access by clicking on the loudspeaker icon. At the end of the broadcast, the interface will close automatically and you'll have the opportunity to fill out an online evaluation. Please take a couple minutes to do so. Your response will help us to plan future broadcasts in this series and improve our technical support. Now I would like to turn it over to Tasmeen.

TASMEEN SINGH: Thank you, everybody, for your time today. As most of you are aware the state partnership grantees of the EMSC program have been responsible for implementing EMSC performance measures in their state through the state partnership program. Our goal today is to talk about the new implementation manual for the state partnership performance measures and to go over the changes that we have previously informed you of for these performance measures. I'm going to be going quickly today in order to leave time for questions at the end but we will hold three conference calls after this webcast in order to answer any additional questions that we may not have gotten to today. The dates of those conference calls are Wednesday, December 12th, Monday, January 7th, and Thursday January 17th. They'll all be at 1:00 p.m. Eastern Standard Time. So again, we invite you to join us on one of those three conference calls if you have a question that we don't get to today. And again, the information for the conference calls with call-in information will be sent by the National Resource Center, the NRC, in the next few days. With that I would like to get into the meat of our presentation. As I mentioned, we're looking at the major revisions for the implementation manual for the state performance measures.

Next slide. What the new changes are going to be as well as the new format for the revised implementation manual and show you what you'll be required to enter into the HRSA electronic handbook or EHB at the end of your year. We're also going to cover the supporting documentation requirements for your performance measures.

Next slide. Next slide. So the overall purpose of the EMSC performance measures is really to ensure that we have a national picture of how EMSC is doing at the state level. The performance measures were developed in 2005 and they were developed in order to demonstrate national outcomes for EMSC. How is the infrastructure for pediatric emergency care at the state and local level? Our purpose in making all of the state partnership grantees work on these performance measures and collect data is to get a national picture of what the pediatric infrastructure for emergency care looks like at the state and local level. The key to the performance measures is really to ensure that we have systematic data collection across all 50 states, the district of Columbia and our five territories.

Next slide. The performance measures really represent the best thinking of the EMSC experts throughout the country on how to improve the care for children. They were initially developed with input from many national organization grantee groups and national experts in EMSC. Our current changes to the performance measures reflect our experience from the first year of implementation. They have really come from the changes that the grantees have recommended based on their experience with the first year. For 2007 and 2008, the priority is to continue collecting data and for the nine new grantees to begin data collection to get baseline data. The second priority is to ensure that your advisory committee begins strategic planning on how you'll address the gaps you may have already found from those states that collect data in 2006. So really, there are two prying Tories. One

is to collect data and the second is to review the data, understand the gaps in your system and again planning for how to make planning to your state's healthcare system to improve the care for children.

Next slide. So I'm going to go over the new format for the implementation manual. As I mentioned before, the implementation manual has been changed based on feedback from all of our grantees. We recognize the first year of the performance measures was challenging for many of you because it was the first year that all of these performance measures were being implemented across 50 states. It was a learning experience for the EMSC program as well. And so we've taken the lessons learned to provide you with a more streamlined manual that we hope will ease your implementation of the performance measures.

Next slide. The manual includes the following information for each of the measures. First of all, we have the list of the performance measures that you are responsible for. In each section we've identified the significance of the measure and we focused on how you can sell this measure to those in your state or territory that need to understand why these performance measures are important and how to implement them. Pay attention to that significant section. We've also provided in that section a list of resources that you can use as justification for why this measure is important and in one of the appendixes we've given you a paragraph description of the each of the listed resources so you have some justification you can take to your stakeholders as to why these measures are important and why the national program is focusing on them. We've also provided definitions of key terms used throughout the manual. If there is ever a definition that you're not sure as to what we mean exactly, you can go back to the definition sections to understand how we're using a particular term.

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Next slide. We've also given you some options for data collection. I'll go over those in more detail with each performance measure and giving you a snapshot of what you'll be required to enter into EHB. Lastly, we provided some tips for strategic planning. Namely, how you're going to go ahead and make some system changes to address the gaps in your system. Again, we encourage you to pay particular attention to the strategic planning session and also to contact your NRC representative if you need additional help.

Next slide. We've also provided some appendices. We've provided an annotated bibliography so you have national justification for focusing on these measures. We've also provided some case studies that highlight best practices and lastly, a crosswalk that shows how the performance measures are relevant to the 2006 Institute of Medicine reports, emergency care for children growing pains. Again, all of these are resources to help you sell the performance measures to your stakeholders.

Next slide. We also have a general consideration section of the revised manual and the general consideration is just a broad brush overview of the terms that we're using and some implementation considerations. I'll go over that right now.

Next slide. First, as we have mentioned before, the changes to the performance measures are in effect for the current partnership grant cycle which is March 1, 2007 to February 29, 2008. Most states are aware that the EMSC program looked at the data that they entered for 2006 in July of this year. And sent a letter to all states in September of this year that highlighted the major changes to the performance measures. The changes that each state received. You also received a review of your 2006 data collection. We encourage each

state to carefully review that letter in order to understand how data was collected in 2006 and what you should do to better collect the data more accurately in 2007.

Next slide. I also want to highlight the data must be collected each and every single year and that data collection needs to finish by the end of the grant year, which is the end of February each year. There are four measures that require data collection. 66A, 66B, 66D, and 66E. This year the one major change is that we're asking all grantees to make sure that they consult with the national EMSC data analysis resource Center for their data collection efforts. This is to make sure that all states and territories are collecting data in the same systematic fashion so we have consistent data to get an accurate national picture. There are two basic ways that grantees can collect data. One is to survey and the second is to use inspection reports. Throughout this presentation, I'll give you the specifics for each performance measure. A general consideration if you are going to use surveys is that you must get a response rate of at least 80% and again, this is to ensure that the data you collect is accurate. 100% is always the ideal standard but we understand it is not always possible so 80% is the minimum standard established if you will be doing surveys.

Next slide. The second data collection method is inspection reports. This is the preferred data collection method because it is an independent source and doesn't have some of the limitations that self-reported survey data has. If you are going to -- if you have an inspection process in your state and have access to this data, there are two ways to collect it. One is to get aggregate electronic data. If you are going through that source, please make sure that you are going to be able to query the specific data points for our performance measures or you can collect the data by reviewing your paper inspection reports. If you go that route, you only need to review all of the available reports. That means that if your state is on a two-year cycle for review, you can review those reports

that are available. As I mentioned before, all data collection should be done in consultation with NEDARC. We're asking all grantees get their surveys approved through them or that you've consulted. On how to review your inspection reports.

Next slide. One item that is new for this year is that we are allowing an option to give an exception from data collection to certain states and territories that have a state mandate that with an enforcement process that basically assures 100% availability for each specific performance measure. I'll talk more about what you need for an exception from data collection but please remember that in order to get an exception from data collection you need to tell us how you're assuring the performance measure is available in your state 100%. Therefore, the state mandate has to be fairly strong, specific and have an enforcement process that assures 100% availability. This is fairly difficult but we are providing it as an option to the few states who do have such a strong system in place that they can guarantee 100% availability.

Next slide. We've also provided you with a list of supporting documentation for each performance measure. As you will note, the grant guidance for state partnership program states that the EMSC program and HRSA may want supporting documentation and we've given you examples of what supporting documentation maybe asked. Now I'm going to go into the changes for each performance measure. Again, I'll be going through this very quickly. We encourage you to ask questions and the questions we don't get to at the end of today we will answer on the three conference calls that I highlighted earlier in the presentation. So let's start with performance measure 66. As many of you know, performance measure 66 is to ensure the operational capacity to provide pediatric emergency care. We have five sub measures to specify how we're going to do this.

The next slide. The first one, 66A, is that by 2011 90% of agencies will have pediatric medical direction for BLS and ALS providers online. Or territory where the state or territory has a definition for pediatric online medical directions you're welcome to use that definition. However, we found in 2006 most states did not have a pediatric-specific definition for online medical direction and so we've provided one here for you. As you can see the definition is very broad. It is to say that it's an individual that is available 24/7 on the phone, radio or other electronic communication to EMS providers who need online medical direction when transporting a pediatric patient to a hospital. The person must be a medical professional, deemed to have pediatric expertise by the hospital in which they work. This definition has been purposefully left broad. Many grantees have requested that the EMSC program specify specific years of experience or have specific classes in order to be deemed of having pediatric expertise. We've avoided doing that because there are different resources available in each state and territory. As this is a national performance measure we wanted to leave it broad enough that every state and territory can try to meet this performance measure. So we haven't specified that you need to have a specific number of years of experience or specific classes that you've taken in order to have pediatric expertise. We're really leaving that for the state hospitals to decide based on the resources that are available in the state. However, we again encourage states to develop their own definition that will incorporate the resources available in that state and ensure that pediatric medical direction is available. Now, for surveying purposes if an EMS provider doesn't know the pediatric expertise of the person they are talking to we've asked for them to simply respond as to their confidence in the information they received while obtaining medical direction. The templates for surveys do have the question worded appropriately.

Next slide. For offline pediatric medical direction we've made the definition specific to pediatric protocol. Treatment guidelines or protocols used by EMS providers that are pediatric specific and available at the scene of an emergency.

Next slide. And we've defined at the scene of an emergency as medical direction available to the EMS provider from the time that the patient care unit is dispatched through patient transport to the hospital. So again, this is while they're responding to a 911 call at all times that they have access to the patient.

Next slide. Now, as I mentioned before there are always two data collection options. Surveys and inspection reports. For 66A if you're going to use a survey you're required to use the template or get your survey approved to assure we're getting consistent data across the states. For inspection reports, if you have a way of capturing this information you can use inspection reports. Again, we found that most states don't have 66A specific information in their inspection reports so we're asking you again to consult NEDARC if you want to go that route. Now, if you have a state mandate and think you may qualify for an exception from data collection, we ask you to make sure your state mandate includes specific language directed at pediatric medical direction and that the mandate has some enforcement process. As I mentioned before, we want to assure that pediatric medical direction is available in each state and territory. So if you have a mandate that basically guarantees 100% availability of pediatric medical direction, then please send the NRC representative for your state a description of what that mandate is and the enforcement process along with a copy of that legal mandate and we will review it and respond back to you as to whether you qualify for an exception from data collection.

Next slide. Now, for offline pediatric medical direction, again if you have a state mandate that essentially assures that all ambulances in your state have pediatric protocols available to the providers, you can apply for an exception from data collection. Specifically what you would need to show is that all units are required to use some pediatric protocols and that this is available statewide. The protocols don't have to be consistent across the state but they do have to be required and available statewide. That there is a training or if you're applying from -- we want to assure your EMS providers are aware and knowledgeable of the pediatric protocols and that the pediatric protocols are available in all patient care units. If you have a state system that assures pediatric protocols on all ambulances you can apply for an exception from data collection and again you would contact your National Resource Center representative to submit that documentation. Here is what your entry will look like in 2007 for -- for performance measure 66A. Unlike last year, we are not lumping together online and offline medical direction. You are actually going to be asked to tell us the percent of agencies in your state or territory that have online pediatric medical direction for BLS providers, online pediatric medical direction for ALS providers.

Next slide. Offline medical direction for BLS providers and offline medical direction for ALS providers. We've separated the online and off line and separated BLS and ALS providers to allow you to give -- now, in terms of supporting documentation, if you use surveys we would expect you to have a copy of your survey results from NEDRC or the raw data from your surveys. If you used aggregate data you can see we're asking you to give us a list of your data elements, the queries you've used and the final results. A copy of the inspection reports and a copy of the tabulations of the data collected. Again, this is supporting documentation that you need to have on hand should the federal program request it. And

again if you did receive an exception from data collection you would have a letter of approval that you could use as supporting documentation.

Next slide. Now we get into performance measure 66B. Again, as most of you know, 66B is the availability of pediatric equipment as outlined in the 1996 joint guidelines and we want to make sure by 2011, 90% of all BLS and ALS patient care units in the state or territory have essential pediatric equipment.

Next slide. Again, there are two data collection options you can survey and use the template or you can use inspection reports. If you have a way of making sure that your inspection reports capture all of the information that we're asking. This year we're asking states to give us specific information on what pieces and sizes of equipment are missing from each of your ambulance units. Last year states reported it on the agency level. This year we're asking you to report data on the patient care unit level. We mean the ambulance, fire truck, chase car or actual unit that is used to provide patient care. The reason we've moved to patient care units, last year that's how most people interpreted and reported the data and a more accurate picture of how many ambulances or patient care units have the required equipment. When we're telling you to what sizes and what pieces of equipment you're missing is for the EMSC program to work with national organizations to update the list. We recognize that the list is a little bit outdated and we're working with several national organizations to update the list. The data that we get from the states and territories will help us ensure that the list that we produce for next round of performance measures is up to date, accurate and reflective of the equipment that most states and territories are able to have on their patient care units. The other change for this year is that we are also providing an option for equipment that is out of scope. Last year states and territories just counted equipment as missing -- allowed to have that piece of equipment

because their state medical director would not allow the use of that equipment by EMTs and paramedics. This year you can tell us what pieces of equipment are out of scope. However, we ask that you please verify with the NRC that a piece of equipment is actually out of scope because of medical reasons and not because of political reasons such as the inability to purchase due to cost. If your state has a system in place that assures 100% availability of pediatric equipment you may be able to get an exception. An inspection process that is regular and covers 100% of the patient care units in the state and a documented enforcement process that takes an ambulance or patient care unit out of service if they don't have the pediatric equipment. Again, if we provide you with an exception from data collection we're essentially saying that the state has assured 100% that equipment is available on all patient care units. Therefore, the state inspection process has to be fairly strong to make that assumption.

Next slide. Now, here is what your EHB entry will look like. We'll ask you to tell us the percentage of BLS patient care units. Again, this is now the unit level and not the agency level that have the essential pediatric equipment as defined by us in the 1996ASEP guidelines and the percentage of ALS patient care units that have the essential equipment. One thing I failed to mention early is that we're counting all levels between ALS, BLS as ALS. If you have intermediate services in your state or territory, lump that data together with ALS.

Next slide. Similar to 66A, supporting documentation for this measure will include copy of your survey results or again the list of data elements, query parameters and copy of final results if using inspection reports. Again, if you do have an exception from data collection you'll be able to have a letter of approval stating as such.

Next slide. Now we get into performance measure 66C. Again as you know it's the existence of a statewide or territorial or regional standardized system that recognizes hospital able to stabilize pediatric emergencies for medical and trauma emergencies.

Next slide. As you know, this data does not require specific data collection. We're just asking states to tell us whether or not they have such a recognition system in place in their state or territory. Supporting documentation could include the facility recognition application packet. So essentially the information that tells us how facilities are recognized in your state or territory, the criteria that facilities must use and a list of hospitals participating in this recognition program. If you have not met the measure you actually have an option to tell us where you are in terms of meeting that measure. In the full implementation manual we'll be giving you a scale of 0 to 6 to tell us how far you've gotten in terms of your strategic planning to try to meet that measure.

Next slide. So as you will see in EHB entry we'll ask you to tell us yes or no whether you have a recognition system in place for medical, pediatric emergencies, for trauma pediatric emergencies, the number of hospitals that have been recognized under the program and if you answered no, meaning you don't have a recognition process in place, we're going to ask you to assign yourself a score between 0 and 6 of where your state is in the process. Again, the full implementation manual has specifics on where your score would be depending on how far you've gotten in getting a recognition process in place.

Next slide. That brings us to performance measure 66D and E. Again, as most of you know, 66D is the percentage of hospitals that have pediatric interfacility transfer guidelines and 66E are those that have interfacility transfer agreements. Again, as most of you know, agreements are actually legal agreements between hospitals to transfer patients between

them. Guidelines are the who, what, when, where how the transfer will occur. We've identified six components of pediatric transfer that should be included under guidelines.

Next slide. And here are those six components. The first is that they have a defined process for the initiation of transfer including the roles and responsibilities of the referring facility. The second is a process for selecting the appropriate care facility. The third is the process for selecting the appropriately staffed transport service so basically the transport service, whether it needs to have a nurse, a physician, etc., to transport the patient.

Next slide. The process for patient transfer so how informed consent will be obtained. The plan for transfer of patient information, so transferring the medical record, the signed transport consent, personal belongings, etc., lastly the process for return transfer of the pediatric patient to the referring facility if appropriate. These are the six components that your hospitals should have in place under interfacility transfer guidelines and they should be pediatric specific.

Next slide. We have given you an updated definition of interfacility transfer guidelines and highlighted that interfacility transfer guidelines can be out of state or territory. So we have several states and territories where they may have interfacility transfer agreements and guidelines between hospitals within the state but to get definitive pediatric care they need guidelines and agreements in place outside the state or territory. We've updated the definition to reflect that.

Next slide. Similarly with interfacility transfer agreements we've updated the definition to allow for agreements to be in place outside the state or territory in addition to inside the state or territory.

Next slide. Now, there are two data collection options for both agreements and guidelines. Again, the first is surveys and you would be surveying your hospitals, all hospitals that have an emergency department in your state or territory. And you would use either the NEDARC approved templates or consult them if you are using your own surveys. From their hospital associations or other surveys conducted in the state. If you have another data source for the performance measure consult them to ensure the data source has all the information we need for the performance measures. Again, if your state has a mandate in place that basically assures that all hospitals have agreements and guidelines in place with specific guidelines in place for pediatric transfer that include the six components you could apply for an exemption from data collection. Contact your NRC representative, review the information and see if you qualify for an exception.

Next slide. As I've mentioned before the exception from data collection needs to assure that all these performance measures are in place 100%. Therefore, as you can read in the slide you have to have a very specific mandate that covers pediatric patients and includes the six guidelines, the six components for guidelines, or specific language for transfer agreements.

Next slide. Here is what your EHB entry would look like. We'd ask you to give us the percentage of hospitals that have written pediatric interfacility transfer guidelines that meet the six components and the percentage of hospitals that have written agreements for pediatric transfer.

Next slide. Supporting documentation is similar to what we've asked for on the other performance measures. If you're using surveys, a copy of the survey results, if you used

the system or a copy of the paper surveys and the tabulation of your data. Again, if you are using another data source, we ask you to consult NDRC and decide up front what your supporting documentation will be before you begin your data collection.

Next slide. That brings us to performance measure 67. The major change to this performance measure is that we are now including both basic life support and life support providers. Many states told us the majority of the providers in their state are BLS providers and it is important to assure that those providers have pediatric education in addition to just the ALS providers. The program agreed and so we've changed the performance measure to reflect both BLS and ALS providers.

Next slide. As you know, this data does not require specific data collection as you're telling us what the requirements are for pediatric education, for recertification of BLS and ALS providers. If your state is a national registry state, meaning your state, 100% of the providers in your state are required to go through the national registry for recertification you can say yes and provide the number of hours that are required by national registry. If your state is a combination state meaning some providers go through national registry and some providers go through a state system, you tell us what the lowest standard is for pediatric education. Meaning if national registry requires eight hours for ALS and six hours for ALS, give us six hours since it's the lowest standard. The supporting documentation for this measure would be a copy of your state or territory or your regional mandates describing the requirements. So if your state has requirements allowing for choice of options and it's not pediatric specific, then you would not meet this measure.

Next slide. Here is what the EHB entry would look like. We would ask if your state or territory has adopted requirements for pediatric education, again for BLS providers and

separately for ALS providers. If yes, we're going to ask you to tell us what the total number of hours required are for recertification and of those total hours, how many are pediatric specific.

Next slide. Again, this green shows you the breakdown between BLS and ALS. We'll also ask you to tell us if you're answered no as to what the barriers and challenges are in your state for getting pediatric education as a requirement. That's to help us understand what challenges you're facing to see if we can help you from the national level.

Next slide. That brings us to performance measure 68. The last performance measure which is to ensure that all of the EMSC requirements that we've talked about are made permanent in the state EMSC system. This measure has four sub measures. The first is the establishment of an EMS advisory committee. Make the third is to have a full-time dedicated EMSC manager in your state and the last is that all six of the EMSC priorities are integrated into a state mandate so your state statute, rules or regulations to ensure that they are permanent and continue on.

Next slide. For 66A -- for 68A, the establishment of an advisory committee we previously asked for 14 members with fairly stringent requirements for what those 14 members needed to look like. After hearing from many of the states, we've now sought requirements of the State of territory. We recognize that each state has unique needs and may need to add staff in order to meet the performance measures. The eight members we're requiring are listed here. One thing I want to add is that we're asking that states do not have duplicate roles for these members. We are requiring that there be no duplication in roles. One person wearing two hats for the emergency physician, for the nurse with pediatric expertise and the EMT and paramedic. For the clinical roles we're asking that there be a

unique individual that meets that particular rule requirement. We also want to highlight that the family member representative is a very important member of your advisory committee. We ask that you ensure this member is a person of the community. As I mentioned before, we are reducing the number of required members to eight but there are several other members we are recommending states have. We're asking you to choose these members based on what specific performance measure you are having trouble meeting and what your strategic planning is going to be for the next few years. There are several members listed that we're suggesting. For example, if your state has not met performance measure 66D and E, interfacility transfer, then a hospital association representative may be an appropriate additional member to have on your advisory committee. As you can see we've provided several other members who may be useful to you as you try to meet these performance measures.

Next slide. Other changes for performance measure 68A. In order to meet this performance measure your advisory committee meets four times a year. It can be face-to-face or conference call. We recognize that some states have travel challenges and therefore you can have all four meetings via conference call. We stress that face-to-face meetings are always preferred. If one of the core committee members is unable to attend they can designate an alternate individual to assure that there is representation. We've also changed that the advisory committee can be outside of state government control. So where previously we had asked for it to be mandated committee, now it can be outside of the state or government control so that they can be advisory to the grantee. The committee can also be part of an existing committee that already exists as part of the state. For example, if there is a subcommittee, a pediatric subcommittee or a pediatric committee you can use them on this board as long as they have all the eight required members we specified. And lastly, if you do have a limitation in your state government of

what members can be on an advisory committee, we encourage you to develop your advisory committee outside the state government but you must have the eight members and meet -- supporting documentation for 68A again we don't require specific data collection but you should have available for each meeting that you have a sign in sheet, agenda, meeting or notes as supporting documentation that your advisory committee did meet four times a year and that you do have the eight required members.

Next slide. The EHB entry for this performance measure will ask you whether or not you have the eight required members and also ask for the number of meetings that you've had between the grant year.

Next slide. For performance measure 68B we don't require specific data collection. However, supporting documentation could include a copy of your state mandate that describes or illustrates the requirement for a pediatric representative on the EMS board.

Next slide. Again for performance measure 68B we will be asking you yes or no whether there is a pediatric represent -- representative on your board and whether it is a mandated position. We understand that there are many states or territories where there is a pediatric representative on the EMS board but the position is not required. So we've changed the EHB entry to allow you to give us more specific information of what your state or territory looks like. If you haven't met this measure we're going to ask you to tell us what some of the challenges are to meeting this performance measure.

Next slide. For 68C again there is no specific data collection that's required. This performance measure again requires that there be one full-time EMSC manager in each state or territory. The person can be funded through the federal EMSC program. State

partnership grant or using state funds. The preference is the person be state funded so that again it's not dependent on federal funding. Supporting documentation for this performance measure would include the name of a person in that position and a job description that illustrates that they are full-time dedicated to EMSC issues.

Next slide. Here is what the EHB entry would look like for 68C, a yes or no question as to whether or not you have a full-time EMSC manager. We'll also ask you as to how the position is funded, whether it's funded through state funds or federal funds.

Next slide. Lastly, performance measure 68D again doesn't require specific data collection and supporting documentation would essentially be copies of state mandates that show that all of the six EMSC priorities are integrated into your state or territory system. Since this performance measure is a long term performance measure meaning it will take several years to get priorities into state rules, regulations or statutes we're going to also ask you to give us an assessment of the progress you have made towards meeting this performance measure. In the full implementation manual we've given you a score from 0 to 5 that allows you to tell us exactly where you are with meeting this measure.

Next slide. Again here is what the EHB entry would look like. Yes or no to whether you have integrated EMSC priorities. If you haven't, give us an assessment of where you are on a scale of 0 to 5 with -- so now that I've gone over all of the performance measures there are a couple other things that I want to mention. First is that in 07 and 08 for the imagine or tease of the states you've already submitted your baseline data in 2006. The new -- for everybody else you're submitting continuing data. In addition to what you submit in EHB, we're also going to ask you to complete an online data worksheet which will be hosted on the website. The purpose of this online worksheet is to understand how you

collected data to assure that the data you've reported into EHB is consistent with what all other states are reporting and was collected with the same standards that the other states have used. For FY08 and 07 all states should stay on track with having regular advisory committee meetings and ensuring you're looking at the data you collected to plan for where there are gaps in your system and make system changes to assure that there is good pediatric care available in all emergency departments and all EMS systems across the country. We're also going to be sending out the new implementation manual today to all states and territories via email and it will also be hosted on the NDARC website. They'll all be receiving the full implementation manual today via email or web link depending on your ability to receive attachments. If you have any questions whatsoever I do encourage you to call your National Resource Center representative. We want to make sure that all states and territories are comfortable with this manual and if you do have questions, you have an opportunity to get them answered. Next slide. As I mentioned there are several resources available to you. There are many webcasts that are archived on MCH.com and also archiving this webcast so if you missed it or want to go back over it, it will be available to you. There are two resource centers at your disposal. The EMSC national center and the data analysis resource center available to assist with any questions and the implementation of these performance measures.

The next slide. We've provided contact information for the federal EMSC program officers Dan Kavanaugh and Tina.

Next slide. Also contact information for the EMSC National Resource Center. You can see my phone number and email address as well as the director. I want to note the phone number for me has changed. The new number is now 202-476-6866. Please do make a note of that. We'll now go ahead and open it up to questions from the group.

DAN KAVANAUGH: We have about five minutes to answer some questions and I'm going to pull some up here. One question is some of these are statements followed by questions. It states the performance measures in the electronic handbook haven't been updated. If we report last year data end of year data won't be consistent. If we report current data the numbers won't match the performance measure in the EHB. How are we to report data for our continuation application?

>> That's a great question and actually a very good point as well. The EHB for the continuation applications which most states are currently working on has not been updated to reflect these new changes. So you would be entering the data that you entered in last year. However, when you submit 2007 data on July 16, 2008, the EHB will look like what you've seen today.

>> Another question is what is the specific goal for performance measure 66A which relates to online and offline medical direction? There is a statement following it. If it is to identify the availability of appropriate medical direction, then you need to state that.

>> I think the intent of 66A is to ensure that an EMS provider in the field can contact somebody that has more pediatric experience and expertise than they do so that when they have a child, they have someone that is at a higher level of care than they're trained at to be able to provide them with advice and guidance. That's the intent of the measure. We're being a little bit simplistic in this round of the performance measures in asking the providers, do you have access to a pediatric expert when you need it? Many states are well beyond that in that they have assured pediatric medical direction by defined that there is medical direction available to all of their EMS providers. So for this first round of

performance measures, the EMSC program has taken a very conservative approach to just asking and trying to figure out where the states are with just having any pediatric expert available. In future years, we'll definitely consider whether we need to be a little bit more aggressive, I guess, with requiring that that pediatric medical direction be more -- have specific criteria that they're supposed to meet.

>> Another question is does receiving an exception from data collection mean that you have met the performance measure? I think the answer to that it does not mean you've met the performance measure, it just means that you don't have to do a -- necessarily a survey in order to meet that measure that there is another method within your state that, without doing the survey to see where you're at. It doesn't mean you met the performance measure. You still need to meet, for example, one of the performance measures being 90% of. You would still need to meet that. You have another way to meet it besides having to survey, for example, all ambulances in your state.

>> Right. And the only thing I would add to that is that many of the performance measures last year we sort of asked the question very black and white, yes or no, did you meet the performance measure. Where as it's not that black and white. Let's take the example of the advisory committee 68A, you may have met the measure in 2006 because you held four meetings and you had the required membership but you may not meet the measure this year because you didn't meet four times a year so I think every single year you do have to confirm that you are continuing to meet the particular measure.

>> Another question is my state does not have a state medical director so each agency's medical director allows different procedures for intermedial life support providers. Some

ALS providers cannot do IOs while others can but may not be able to do intubation. How do I report this since it's per agency not statewide out of scope?

>> Our new requirements help you out considerably because we're asking you to report the data by patient care unit. O needles and four ambulances in your state are out of scope because your medical director is not allowing the use of IO needles for that agency. You can report the data specific to each particular patient care unit. So for whatever agency the IO needles are out of scope you would report those as out of scope. For those not out of scope you would report them as yes or no to having that piece of equipment.

>> This question is related to performance measure 67. What if your state has a state regulatory mandate that requires pediatric continuing education during a re license.

>> We would need a little more information as to what the state requirement is. If there is a requirement to have pediatric hours but there is no number of hours specified, how do you assure that there are pediatric -- that pediatric education is provided? Do you have particular training requirements or standard training curricula your state uses? I think we would need a little more information and whoever asked that question I would ask that you please give us a call after the webcast and see if we might be able to give you a better answer.

>> Regarding performance measure 68A reference to the advisory committee, if a core member isn't present at a specific meeting and they don't send a substitute, does that mean we don't meet the measure?

>> No. As long as that member is a member of your advisory committee, they've committed to being on your advisory committee. If they just miss a meeting it doesn't mean you didn't meet the measure. To meet the measure you need four meetings a year and that you do need to have eight members that have committed.

>> I think we have time for one more. This is related to the draft survey. It says the draft survey from NEDARC to assess pediatric equipment per ambulance is 23 pages long. I'm concerned that our 200 or more ambulance agencies will answer this -- that can be asked.

>> Again, we do recognize that by asking you to collect data specifically on each piece of equipment and each size that's missing does increase the length of the survey. What I would recommend is that you work with us to see whether you can -- whether first of all to make sure that all of the pieces of equipment are considered in scope for each of the agencies that you're sending the survey out to. The template survey that they send out is for BLS, ILS and ALS services. If you're sending it out to just a BLS agency you could remove the ILS, ALS questions. If you're sending it out to just an ALS questions you could remove the BLS, ILS questions. I encourage you to call NEDARC and work with them on that. There will be some length to the 66B survey again because of the complexity of information that we're asking all states to obtain.

>> I would like to thank Tasmeen for leading the webcast. Thank you all very much for all the work that you do every day in your state to make kids safer. We really appreciate your work and we know this has been a change for folks in terms of the meeting the performance measures and appreciate your working on this. This will be archived. We also ask you to fill out the evaluation and to contact either myself, Tina or your state

representative at the NRC for any follow-up questions you may have during this period.

Thank you very much.

>> Thank you.